The Commonwealth of Massachusetts
Department of Social Services

A PROPOSED PRACTICE MODEL FOR WORKING WITH FAMILIES RIGHT FROM THE START

Developed by the

Working With Families Right From the Start

Project Team

Between September 29, 2004 and September 29, 2005

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[Available on the internet at www.mass.gov.
Find "Working With Families Right From the Start"
in the Initiatives box of the DSS landing page.]

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Dear Reader,

For precisely one year to the day, the ninety participants in Working with Families Right from the Start (WWFRFS) have been engaged in fashioning a vision for a new kind of child welfare system for Massachusetts. This document offers their vision to all of you who share their passion for supporting children and families, and asks you to join them in thinking bravely and rigorously about what our future as a child welfare system should look like. These ninety participants—Department staff, parents and families, providers, community leaders, fellow state agencies—have dared to provide a substantive answer to the question, "Knowing what we have been and are, what do we long to be?" Put another way: "Knowing what we have learned, what are we ready to become?"

It is part of the hope and joy of our present circumstances that when ninety people who come to the question from ninety disparate experiences of child welfare join together, their answers to the question are stunningly congruent. There are still debates among the participants about timing, resources, sequence, specificity. But there is a striking unanimity about the direction that the child welfare system needs to move in. While there is much fodder for debate about how we get there, there is no debate about the arc of our progress.

They have traveled a long way together in a year, further than any of us expected when they started out. They have spent days together, researching, remembering, inquiring, listening, debating, clarifying. You may or may not be convinced by all or parts of what they have assembled. You may need to be provoked by what they propose to clarify your own thinking, and to ride the learning curve they have traversed. We hope you will take the time to contemplate their achievement, and speak to it.

Between now and the end of the year, WWFRFS will conduct a "Listening and Learning Tour", inviting many others of diverse experience and perspectives to react to the document and advance our learning. This will be followed by the establishment of a Phase II Design Team after the first of the year. We are very much beholden to the participants in WWFRFS for their courage and contribution, and grateful for their extraordinary diligence and dedication. Their example calls us to expand and continue the dialogue. I look forward to the further enrichment of what they have placed before us.

Sincerely,

Harry Spence

Harry Spence, Commissioner
Massachusetts Department of Social Services

CONTENTS

HOW WE GOT TO THIS POINT, WHERE WE'RE GOING NEXT

Background

A brief survey of the Department of Social Services' policies indicates that most have not been revised since the early 1990's, especially those related to intake. After coming on board in Fall 2001, senior DSS staff informally surveyed those directly involved as staff and family or community partners about how the system was working. In the process, they developed and refined an understanding of DSS Core Practice Values and Mission. They learned that most interviewed felt that an agency-wide overhaul was long overdue. Some felt that new ways of engaging with families needed to be found, approaches that reduced the adversarial aspects of the work. Social workers and supervisors who were found to be working in family centered ways indicated that they did not feel well-supported.

DSS leadership decided to undertake a more systematic approach to assessing the ways in which the DSS policy and practice reflected the DSS Core Practice Values and Mission. To this end, the Intake and Assessment Policy Revision Project was initiated in February 2003. Between October 2003 and January 2004, approximately 250 individuals – including birth parents, adolescents, foster and adoptive parents, community and professional representatives and DSS staff of all levels – shared their thoughts and experiences through focus groups and surveys. The findings confirmed the need for changes in our interactions with families.

For example, the focus groups found that "many participants indicated that intake must be more sensitive to parents' feelings of being invaded and shame that often occur during investigations. They also felt that intake should make problem-solving and services available to families more quickly. Most of the DSS staff and all of the consumer focus groups felt that DSS needs to do a better job of working with families. There should be a more humane approach, one in which the families are treated without prejudice, as people who are struggling with certain challenges, yet striving to be a functioning healthy unit. Family strengths are not being adequately emphasized, nor are those achievements of which the family is most proud. There was an overall sense that the social workers need to achieve a higher level of communication with all parties during intake."

That process was the beginning of a major practice and policy initiative charged with designing a practice model which embodies a family centered and strengths based approach to DSS' delivery of child welfare services, focusing primarily on the first interaction with families. The title of the project, *Working With Families Right from The Start*, contains the multiple meanings which reflect the goals of the project: Working with families; working with families right; working with families right from the start. This paper summarizes that project and the proposed practice model.

Working from a Shared Vision

The **Working With Families Right From the Start (WWFRFS) Project** began with a two day kick-off summit in Fall 2004. The almost 100 member team worked collaboratively to create a shared vision for DSS in the year 2010. The vision is built upon the agency's Core Values which call for practice to be: child driven, family centered, community focused, strength based, committed to cultural diversity/cultural competency and committed to continuous learning. The following is the **shared vision** that guides all of the work of the project:

WWFRFS Shared Vision

- DSS actively engages with families, in helpful, welcoming and supportive ways, to protect children and intervene to achieve safety, well-being and permanency.
- DSS involves families as partners and team members in problem solving and decision-making.
- DSS practice is respectful; supporting families in meeting children's needs for safety, well-being and permanency through clear communication and facilitated access to wide-ranging community resources.
- DSS staff reflects the diversity of the communities served, providing quality professional service that demonstrates cultural competency and linguistic responsiveness at all levels, and is proactive in its approach to improving the lives of families and the communities they live in.
- DSS nurtures a culture of reflection, learning and continuous improvement that inspires staff and families and that sustains itself through political transitions.
- DSS settings reflect respect for families and staff alike, featuring the best available technology, equipment and accessible facilities to support families.

The Work

The team created seven broadly representative working groups, each including DSS social workers, supervisors, area program managers, area directors, regional office staff, central office staff, parents and community partners. Approximately 40% of the project team were representatives of DSS area office staff, 40% were parents and community partners, and 20% were DSS regional and central office staff.

Each group was challenged to examine best practices in a defined area, and use that study and reflection to make recommendations for a practice model for Working with Families Right from the Start. The areas are:

- Engagement and Responsiveness with Families
- Safety
- Well-Being
- Planning Services for Achieving Permanency
- Community Partnerships
- Building a System to Support Practice Change
- Measuring Our Success

From October 2004 through June 2005, the groups met at least one full day each month. In between meetings, group members conducted research and gathered information to share with their working group for discussion and study. The working groups' initial task was to further explore the Core Values by using them to identify the principles that should guide family centered practice. The following is the result of that work:

Guiding Principles for Family Centered Practice

Core Practice Value: CHILD DRIVEN

1. Permanency, safety and well-being of children, as well as that of the people connected to them, form the center of the work DSS engages in with families and their communities.
2. Children's physical and emotional safety is paramount.
3. Children have the right to be part of a safe family.
4. Children have the right to a fair chance in life and opportunities for healthy development.
5. Children have the right to community protection.
6. Children's experiences and perspectives are heard and understood.

Core Practice Value: FAMILY CENTERED

1. The family is the primary source for the nurturing and protection of children.
2. Mothers, fathers and other significant caregivers should be supported and respected in their efforts to nurture their children.
3. Family is defined broadly by its members and includes mothers, fathers, other significant caretakers and their kin who may not be currently evident in the child's life.
4. Family is significant to all aspects of the child's development.
5. Families are entitled to and deserve self-determination, privacy and access to resources and non-traditional supports.
6. Families are capable of change and with support most can safely care for their children.
7. Families are partners in meeting children's needs for permanency, safety and well-being.
8. Families deserve to be engaged respectfully.

Core Practice Value: COMMUNITY FOCUSED

1. Families are resources to one another and to communities.
2. Every community has assets as well as needs.
3. Identifying and strengthening informal and formal resources strengthens children and families.
4. Informal supports are valuable for families and should be sought.
5. Service providers and community resources must be accountable and responsive to the communities they serve.
6. Work with families is focused on identifying and strengthening community resources.
7. Child safety, well-being and permanency are a community responsibility.

Core Practice Value: STRENGTH BASED

1. Engaging families respectfully promotes involvement that focuses on and supports strengths.
2. Children and families have strengths which need to be recognized and supported.
3. Families have the ability, with support, to overcome adverse life circumstances.
4. Families can grow and change through identifying and building upon assets and strengths.
5. Identifying family strengths will inspire hope.
6. Strength emerges from building partnerships between the family, community and DSS.

Core Practice Value: COMMITTED TO CULTURAL DIVERSITY/CULTURAL COMPETENCE

1. Families are diverse and have the right to be respected for their economic, ethnic, racial, cultural and religious experiences and traditions as well as for the genders, sexual orientations and ages of family members.
2. Practice and services are delivered in a manner that respects, supports and strengthens the child's and family's identity.
3. Every culture is recognized for its positive attributes and challenges for families, professionals and communities.

Core Practice Value: COMMITTED TO CONTINUOUS LEARNING

1. Self-reflection, by individuals and systems, fosters growth.
2. Data should be used to promote learning.
3. Opportunities for continuous learning must be widely afforded to professionals, family and community providers.
4. Child, family and community input are essential in the learning process.
5. Positive growth and change must build on identified strengths.
6. Families have a right to participate in services with highly skilled and trained professionals.

The Focus

The working groups then proceeded to identify practice components for achieving their shared vision of family centered practice right from the start. The approach to study and design was one of "appreciative inquiry," i.e., discover and understand what works. Working groups brought together their own experiences, knowledge and learning to identify:

- what is happening in DSS that works well;
- what programs in Massachusetts work well;
- what other states and other countries are doing that improves child welfare services;
- what the research reports works well.

Results

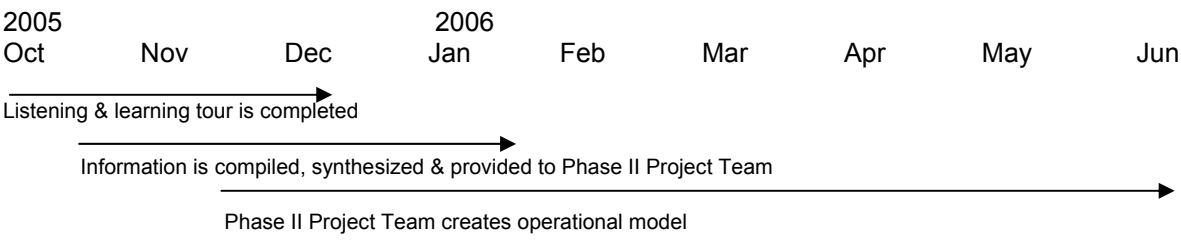
Through the efforts of the working groups, and the built-in sharing of thinking among groups, a model has emerged that uses a collaborative approach to achieve family centered practice right from the start. Working groups defined components of this model in substantial concept papers which detail their study, findings and recommendations. In addition, they have produced a comprehensive compendium listing resources, research, books, program materials, web sites and other materials which have been mined to discover and illuminate best practices for engaging families in child welfare work. The model described here is based wholly upon the descriptions in the concept papers and working group reports.

Reviewing the WWFRFS Concept Model

Having put on paper its ideas for what family centered practice right from the start should look like, along with its recommendations for implementation and follow-up, the team is next seeking to create a dialogue with a wider network of staff, community and parent partners who would be affected by the proposed changes. Throughout Fall 2005, this paper is being presented in a number of forums during a "listening and learning tour" directed at involving the wider community, internal and external to DSS, in the process of setting new directions for DSS's work with families in the initial stages.

The project as a whole is at an early point. Informed by the listening and learning tour, during Phase II the project team will begin to map out an "operational model" specifying what is needed to make the desired changes happen. Written practice design, policies, training and implementation will be developed for review and comment. The goal is to produce materials for Executive Staff review by June 2006.

The following timeline summarizes the process that will be followed during the next several months:



After Executive Staff approves the Final Draft "operational model" materials, the range of steps necessary to support implementation of practice and policy change can begin in earnest. Such steps generally include a workload impact analysis and labor/management review, information technology review and system redesign, planning and delivery of training, community preparation, among others. There is a long way to go and much to be done to turn the project's ideas into reality.

As the model is being considered, reviewers should bear in mind the following objectives the federal government has set for state child welfare agencies to achieve for children: safety, well-being and permanence. The success of the model in establishing new directions for DSS practice and policy will depend in part on reviewers' understanding of and agreement with the model definitions and whether they believe that the model will successfully support DSS in achieving these objectives in improved ways.

Reviewers should also be aware that the team was encouraged to be visionary and creative and afforded the opportunity to develop its model unconstrained by concerns about the legislative, budgetary or staffing impacts. As the project moves forward, it is important to begin to identify those impacts and plan for their resolution if implementation is to be successful. For this reason, the team invites reviewers to identify their concerns about the model's legislative, budgetary and staffing impacts and their ideas for how to resolve them.

Overall Questions for Reviewers to Consider:

1. **In what ways do you share the values and principles that have guided this work?**
2. **What other values or principles do you think should be considered in determining how DSS practice should change to work with families right from the start?**
3. **In what ways do you believe these values will result in new practice that achieves better outcomes for children and families?**
4. **What aspects of the concept model do you think are essential for achieving child safety, well-being and permanence in family centered ways?**
5. **What additions or changes do you think are needed to achieve success?**
6. **What do you see as the legislative, budgetary or staffing impacts of the concept model?**

I. THE MODEL

A. ESSENTIAL FEATURES OF THE "FAMILY ENGAGEMENT MODEL"

Although the working groups were immersed in different components of the practice model, each group identified essential features of practice that must universally and consistently be present in the earliest engagement with families and communities. These are:

- **Safety, Well-Being and Permanence:** An important dynamic that emerged from the working groups is the need to reorient prevailing understanding of the fundamental concerns of child welfare programs: safety, well-being and permanence. Safety, well-being and permanence should not be viewed as three separate areas needing considerations. They are three fundamental aspects supporting the development of a healthy child. When any one of them is lacking, healthy development will not progress. These three components cannot and should not be considered as separate items, even though it is absence of a sufficient level of safety which is the primary justification for the Department's increased involvement in the life of a family.

  The team has developed the following transformative definitions of these three fundamental child welfare objectives:

  > ***Safety*** *is the condition in which the combined individual, family and community capacities (i.e., abilities, resources, intentions) are sufficient to take necessary action to ensure that a child's essential physical, developmental and emotional needs are being met.*
  >
  > ***Well-being*** *is a measure of one's ability to function successfully in home, school and community with satisfaction and enjoyment. Assessment of well-being involves an analysis of the physical (medical and dental), mental, emotional, educational and social development of the child and an examination of the child's functioning in the home, school and community.*
  >
  > ***Permanence*** *occurs when children have relationships that offer safe, stable and committed parenting, lifelong emotional support and family membership status that lasts beyond age 18. It is achieved through the preservation of an intact family or securing of a family through reunification with birth family, legal guardianship or adoption; placement with kin; or the forming of connections with other caring and committed adults.*

  Meeting a child's essential physical, developmental and emotional and needs (i.e., achieving safety) establishes the foundation for her/his well-being. And a critical need, one which encompasses physical, developmental and emotional domains, is a secure attachment with a care-giving adult, i.e., permanence. Therefore, in addition to assessing a family's strengths and needs, initial assessments and service plans must address safety, well-being and permanence at the outset. The same triad must be included in every subsequent re-assessment, review and service plan.

- **Relationships**: Establishing honest, respectful, mutual relationships is essential to every component of the practice model. This includes relationships within the community – among community partners including DSS; relationships with families; and relationships among DSS staff.

- **Responsiveness**: An honest and affirmative relationship is characterized by close attention to the abilities and needs of those involved, and by responding when needed. An essential element of this responsiveness is the ability to work with communities and families in ways that are congruent with their culture, including being able to respond in languages dominant in a community.

- **Respect**: Involvement with DSS should be based on mutual respect and never be associated with shame and stigma. This applies to children, families, partners, and to DSS staff. Eliminating shame and stigma from involvement with DSS is at the heart of the model.

- **Shared Responsibility**: Responsibility for the care of children begins with families. Families are supported by the community and its formal and informal systems. Even when these systems are not able to care adequately for children and families, neither parents nor the community, nor DSS can carry the work of child protection alone. When DSS becomes involved with a family, shared responsibility means that families participate in assessing their own strengths and needs, in determining what services and supports can best help them in raising healthy children, and that the community is available and involved in supporting the family. Further, no one person will be solely responsible for collecting and assessing information and for making decisions which affect families. This work is best undertaken when such responsibility is shared with the family and among staff.

- **Expertise**: Assessing a family's strengths and needs, and supporting the well-being of children, requires a substantial body of knowledge and a high level of skill. Department staff must be well trained and supported in their work. But all DSS staff cannot be expert in all areas. Therefore, staff and community partners with specialized expertise must share the responsibility for providing expert resources for families.

- **Consistency**: The practice model and its principles must be applied in ways that are consistent across the state.

- **Using What We Know Works**: Each working group has emphasized components which have been shown to work. Some are already up and running in Massachusetts. Others have been demonstrated to be successful in other states or countries. In other words, the practice model is neither experimental nor a pilot program.

Questions for Reviewers to Consider about Essential Features of the Model:

1. **What other general features do you think are essential to improving DSS work with families right from the start?**
2. **What additions or changes would you make in the model's definitions of safety, well-being and permanence?**
3. **In what ways do you think the model's definitions of safety, well-being and permanence ensure that no hierarchy or division of these objectives occurs in practice?**

B. COMMUNITY PARTNERSHIP

Philosophy/Rationale:

The practice model which has emerged starts with setting the Department firmly in its community context – where families live, services are provided and DSS partners with others to promote the welfare of children. From this firm base in the community, the model addresses the initial engagement with families and responses to family needs, including what should be included in assessment and service planning.

The project team members acknowledge and affirm that first and foremost, responsibility for child and family well-being, safety and permanence is not held by DSS alone. Through twenty-five years of practice, DSS has learned that partnering with and strengthening communities is essential to improving outcomes for children and families and that children and families do better when they are surrounded by adequate social safety nets and resources. Embracing the core value of community focused practice is essentially a process of recognizing that every community has assets and that families who reside in those communities are not just resources to one another, but share accountability for their mutual well being.

The team recognizes that community partnership requires supportive leadership at all levels and attention to relationships with other state agencies as well as the full range of formal and informal resources. For example, DSS leaders have the opportunity in the new Family Networks system to enhance DSS's connections to providers and to devote greater resources to communities.

DSS, in its role and mandate, shares this responsibility, but should not seek to supersede, weaken or ignore the role of communities in caring for their children, but rather should practice in ways that strengthen community responses by identifying and engaging formal and informal helpers. DSS should endeavor to find ways to improve the family's community connections even when it determines that the family's needs lie outside its mandate. Therefore, a core component of the model is greater actualization of community focused practice. This is a pre-requisite for re-ordering DSS's relationships with families such that they can be engaged in new ways.

In addition, we believe that building relationships with community partners and working with family's right from the start will help change the perception of the DSS state child welfare agency as a punitive agency that was voiced consistently in focus groups and other forums. It is essential that DSS strives to be perceived as an integral part of the community and as an agency that respects and is responsive to all community members. We believe that immigrants and communities of color require particular attention because these populations may not typically work with or use a community's traditional services and supports.

Definition: A common challenge in discussion of community-focused practice is in the definition of "community."

*We define **Community** as: where we live, love, play, work, learn, worship and access services and goods. The community is that area where people converse and congregate during their daily lives. It is where they buy bread, send their children to be educated, seek medical care, pay taxes and fines, try to acculturate and wish they did not have to assimilate. DSS is part of that community and the community is much more than DSS.*

How It Would Work

1. **Revitalize Area Boards:** Area Boards can significantly impact the establishment of strong partnerships between DSS, families, and communities. Based on state statute [Massachusetts General Laws (MGL) Chapter 18B, §§ 13 through 15], DSS Area Boards are mandated to play a significant role in the function and governance of the agency. The current mandated composition of Area Boards is a 21 member body intended to represent a wide cross section of the

community. Membership must comprise DSS consumers, area residents, private and public social service providers, mental health professionals, business leaders and municipal stakeholders. Over the years Area Boards have functioned in a variety of ways based on the needs of local area offices. Some Area Boards are active, some less active, and some inactive. It is recommended that Area Boards should exist in all areas and that they should function in an advisory capacity as a major link between the agency and the community. Area Boards, through their knowledge and understanding of the community, should be catalysts regarding public policy and community issues related to child welfare. While Area Boards may focus on unique local issues and activities, we think that all Area Boards should:

- Bring to the area director issues and concerns voiced by consumers or former consumers.
- Identify needs or gaps in service in the area, and with the area director develop an action plan for addressing the needs. MGL Chapter 18B, § 15, states that Area Boards are "to advise regarding local needs and resources in the development of comprehensive social services." When patterns or trends are identified the Area Board could develop sub groups to work on specific issues or projects.
- Represent DSS by sitting on or participating in existing community coalitions, agency boards, networks, or other community groups. Such connections will promote DSS partnerships with the community and increase DSS knowledge about the community and its resources. The community, in turn, will learn more about DSS.
- Develop links to Area Continuous Quality Improvement (CQI) efforts by addressing questions that are the foundation of the agency's CQI efforts. These include: What have we done well? What can we do differently to be more effective? And, most importantly, have we improved outcomes for children and families?
- Take an active role in "marketing" activities that educate the community about the organizational change taking place at DSS and the Core Values upon which the change rests.

2. **Support and Expand Existing Models of DSS/Community Partnerships:** A number of successful programs which strengthen community partnerships on behalf of children and families in Massachusetts already exist. Each has as its objective the forging of closer working relationships between DSS and a range of formal and informal community resources. We recommend that the following models be supported and expanded to new geographic areas, to include key underutilized resources such as public safety/law enforcement and to assist more families within existing programs.

   - **Patch:** The Patch approach serves as a foundation for much of our recommended approach. Patch is a child welfare reform effort that has been evolving over the past 15 years. A neighborhood (referred to as a "patch" in Great Britain) is encouraged, sometimes through contracting for "seed" money, to structure existing resources in ways that better meet the needs of families and prevent child abuse and neglect. Shared themes include: community partnerships, family empowerment, prevention, team development, resiliency, restorative practice, community resource and information sharing and coordinating and integrating local resources.

     There is strong support for Patch because it is an "approach" rather than a specific model and it can be adapted to **any** area or community. It is a way of addressing child welfare that carries forward DSS implementation of Core Practice Values and the guiding principles in Working with Families Right Form The Start. In their article," Essential Practices of the Patch Approach," authors Zalenski, Burns, and Whitney state, "Patch takes on the work of treating families as partners – not just within specialized meetings but also in every day practice….It challenges people to problem solve together based on a local construction of the needs and resources of children and families. It presents a way of holding DSS mandates through holding a shared role – with families, neighborhoods, and communities – to produce good

outcomes for children." Patch is an example of a project that began with a core partnership between DSS workers and Community Connections family support programs. It is an approach that can provide an infrastructure for DSS in its work of developing and sustaining community partners.

- **Community Connections:** Community Connection Coalitions are organizations made up of community residents, providers, and public/community officials that coordinate prevention focused family support services in neighborhoods or communities. Their primary mission is to strengthen families and prevent child abuse and neglect. The Community Connection Coalitions hold monthly forums where community needs and ideas are addressed and where action plans are developed. These are community based forums, not DSS forums. DSS membership in the Coalitions is welcomed and encouraged. Area office involvement with Community Connections offers one excellent way to promote partnership between DSS and the community.

  We recommend and support the expansion of Community Connections. Currently twenty of the twenty-nine area offices have Community Connection Coalitions. A staged plan is to develop three or four more Community Connection Coalitions in the next five years. In those areas that do not have or will not have a Community Connections Coalition, we strongly support a plan to build a system of Family Support Networks or Family Support Advocates.

- **Family Support Networks:** In areas where Community Connections Coalitions do not exist and even in areas where they do exist, the development and expansion of Family Support Networks is recommended. Family Support Networks are informal collaboratives made up of residents, professionals, community representatives and others. They provide information, support, and encouragement to family members through the sharing of experiences and ideas and through networking. Examples of Family Support Networks are Parents Helping Parents, Parent Advocacy League and Time Dollar (parents of children with disabilities). DSS' understanding, recognition, and support of these family or community initiated collaboratives provides yet another opportunity for DSS area offices to develop partnerships in the community. These groups may indeed provide some of the best help and support for families working with DSS – not only right from the start but long after DSS has concluded its involvement.

- **Connecting Families Program:** Connecting Families is a child abuse prevention initiative developed as collaboration between MSPCC and DSS. It is a unique partnership between agencies, families and communities that strives to support child safety and family well-being. It currently exists in six DSS area offices (Brockton, Hyde Park, Fall River, Lawrence, Springfield and Worcester). The goal of this pilot program is to keep children safe, strengthen families and reduce the need for protective intervention by the public child welfare system. The pilot specifically targets families with unsupported DSS investigations, families who do not have current open cases with DSS and families who have at least one child under the age of twelve. The initiative is based on research that indicates many families with unsupported investigations get re-reported to DSS. There are two particularly salient strategies from the Connecting Families model that are recommendable for use with all families. The first is the **Family Circle of Support Tool** which aids in the identification of a family's formal and informal community connections. The second is the emphasis placed by Connecting Families' **Home Visitor and Family Advocate** staff on providing families with information and guidance to make meaningful connections to a community's formal and informal resources and support networks.

3. **Establish an Information and Resource Specialist Position:**

   The model calls for the creation of a full-time position in each area office to serve as an Information and Resource Specialist. We believe that knowledge of a community and its vast array of formal and informal resources require a full time effort. Presently there is no organized

way of knowing and sharing the vast amount of information that exists about the community or communities of an area office. Furthermore, there are numerous resources beyond the traditional resources most often used by DSS workers that may offer tremendous opportunities for families needing and seeking links to the community. For example, hospitals, libraries, faith groups, school systems, museums, service organizations, Special Olympics, town recreation programs, senior center programs, community colleges, adult education programs, English as a Second Language (ESL) programs, bookstores, etc. offer many services, courses, support groups, interest groups, and educational and recreational opportunities that remain unknown to area office staff. No social worker by himself or herself could possibly access the information about or make connections with all of these resources. Nor can individual workers keep up with the constant changes and additions regarding these resources. We suggest that an Information and Resource Specialist might perform the following functions:

- Provide ongoing, updated information to area office staff regarding a community's formal and informal resources – paying particular attention to the resources that exist in immigrant and communities of color.
- Function as an ad hoc team member or "consultant" to help DSS staff when they are working with families right from the start. Knowledge of potential community supports is critical at the very beginning of DSS's relationship with families.
- Attend Area Board meetings and work with the Area Board in its effort to partner with the community, identify area needs, and develop plans with the area director to address those needs.
- Support and nurture existing partnerships between DSS and the community. The community needs the same kind of attention and focus as do the individuals and families with whom DSS works.
- Participate in the development of a centralized resource information intranet or internet site. This "virtual gateway" could be constructed for DSS alone, with and for all Executive Office of Health and Human Services (EOHHS) agencies and for communities to access as well.

An Information and Resource Specialist will be a significant support to social workers and area staff. We also believe that every social worker has a role to play in identifying, developing and supporting community partnerships. Initially, given budget considerations, the Information and Resource Specialist may be a position that is developed in phases. We think that the changing roles of the current Area Resource Coordinators presents an opportunity to modify or change their job description to be compatible with the focus and tasks we have suggested for an Information and Resource Specialist.

Questions for Reviewers to Consider about Community Partnerships:

1. **In what ways does the model's definition of community create dialogue about community focused practice?**
2. **What opportunities are offered by the model's re-ordering and strengthening of DSS's relationships with communities as the pre-requisite for working with families right from the start?**
3. **The project outlined 3 approaches to building community partnerships. In what ways would you change or expand upon the project's recommendations for improving community involvement to support working with families right from the start?**

C. FAMILY ENGAGEMENT

Philosophy/Rationale:

From a base of strengthened community partnerships and supported by staff who are fully prepared to practice consistently in a family centered way, we propose a family engagement approach that unifies entry, expands screening and redefines the pathways through which families become involved with DSS. The goals of this model are two-fold: first, to avoid DSS involvement in families' lives except when absolutely necessary; and second, when DSS involvement is necessary, to increase the capacity of DSS to work with families in a collaborative process of identifying family strengths and determining family needs. We also wish to broaden the pathway by which non-reported families and those seeking services voluntarily engage with DSS. We believe that this system promotes family and community understanding of DSS as an agency that is responsive to and engages with families in need of services, while ensuring that the safety, well-being and permanence needs of children are met.

This Unified Entry – Differential Response approach provides entry for families through a process that begins with a consideration of safety and whether an emergency exists, focusing on strengths and needs from the outset. It preserves the authority of a protective response pathway for circumstances where it is necessary and appropriate in order to maintain the safety of children. However, most families will access the pathway in which they move directly to assessment, bypassing determinations of "reportable conditions" and findings of "abuse" and "neglect" or "supported" or "substantiated." The approach preserves DSS authority to seek custody of children needing care and protection under existing statutes regardless of the family's entry pathway. Fundamental goals of this approach are to:

- Provide for children to be safe in their homes
- Seek family strengths as a basis for growth and change
- Set aside the issue of fault in favor of solutions
- Work in partnership with parents to identify family needs

Definitions:

Reinventing Child Welfare Language: *This approach aims to encompass those concepts traditionally referred to as "child abuse and neglect," "allegation," "reportable conditions," "alleged perpetrator," and "substantiated" or "supported." However, these determinations are not required when the Family Assessment Response is used and some may even be irrelevant to the central concerns of the Protective Response. For these reasons, we have deliberately omitted those terms from our list of definitions, and we avoid applying them as central concepts in the model. We will seek broad input on new language and definitions for the future policy, including the definition of "caretaker."*

Teaming: *A cross-functional team model will be used in which members are drawn from different functions, and organized in terms of roles and responsibilities. The screening team will consist of screening social worker, supervisor and manager. The Protective Response team will include a Protective Response and Family Assessment Response worker. The Family Assessment team will be composed of at least two social workers with the family.*

Screening: *A brief intervention (3 business days maximum) which assesses the nature of the request/referral and identifies the appropriate differential response. The screening includes a brief safety assessment.*

Safety Assessment: *Periodic review to ensure that the combined individual, family and community capacities are sufficient to take necessary action to ensure that a child's essential physical, developmental and emotional needs are being met.*

Protective Response: *A brief intervention (10 business days maximum) focused on determining whether serious harm or threat of harm to a child exists.*

Family Assessment Response: *A short term (30 business days) intervention aimed at collaborating with the family in identifying the family's strengths and needs, ensuring safety of the child, and determining service needs.*

How It Would Work:

1. **Unified Entry:** This approach will provide a single entry point for families (whether by voluntary request for services, referral, or protective concern), and will utilize a number of pathways responding to families' unique strengths and needs. While the entry point may be the DSS area office, a court, or a statewide hotline or response system, the entry process will be uniform and organizationally integrated.

   Key practice elements include:

   - All responses utilize a family centered, strength based, solution focused approach.
   - A team approach for entry and response decisions.
   - A family centered approach that includes families in decision-making and teaming with the Department.
   - An approach that defines family broadly, based on information from the family, and seeks to identify and reach out to parents/significant caretakers who are not immediately evident as soon as possible, when appropriate.
   - An acknowledgement that each family has a unique culture derived from its heritage and experience, about which the family is our teacher.
   - A reframing of the approach to protective concerns which seeks solutions rather than blame.
   - Speedier responses, e.g., up-front service provision, human contact within short time frames
   - Continued coordination with law enforcement agencies when appropriate.
   - **Services Provided When Need is Identified:** The team also recommends that services must be made available to families as soon as a need is identified. Responsiveness to family needs requires that interim plans be developed whenever necessary. Therefore, services must be available during the Screening Phase, as well as during Protective Response and Family Assessment Response. Again, community partners share in the responsibility of ensuring that needed services are available. The model anticipates greater ability to do this in a mature Family Network system.

2. **Expanded Screening:** Except where the request is clearly for information only, all families, regardless of mode of initial contact with the Department, will receive a brief **screening and safety assessment**. This screening and safety assessment will determine which initial response is most appropriate for the family. The decision will be based on information from collaterals and, in some situations, from contact with the family, possibly even a home visit. Except where information or information and referral are clearly the identified request, the decision about the initial response should not be made by one person alone. It is recommended that the decision be made jointly by the social worker, supervisor and a manager. It is recommended that, except in emergencies, the screening function, expanded under this model, be completed within 3 business days.

   Expanded Screening outcomes include:

   - Whether the referral involves a child, or a youth under age 23 whose DSS case closed at age 18. If the referral does not meet either criterion, information and referral services will be offered, and the referral closed.
   - The current, immediate status of the child's safety and whether an emergency response is needed (initiated within 2 hours).

- Determining appropriate response pathway.
- If a caretaker is not involved but the report or referral indicates that a child has been or is being seriously harmed, a discretionary referral to the District Attorney will be completed.

3. **Differential Responses:** If a situation brought to the DSS door involves a frivolous report, DSS respectfully declines to become involved. For matters involving a child (i.e., a person under age 18) or a youth under age 23 whose DSS case closed at age 18, the outcome of the screening and safety assessment is referral of the family to one of three initial pathways: Information and Referral, Protective Response, and Family Assessment Response.

   - ***Information and Referral:*** The response for requests which ask only for information, or for circumstances which may be more effectively addressed eventually through Family Network referral or through referral to another agency or community-based organization. Information and referral responses include: information only, information with a referral, information and referral with follow-up. In order to ensure that information provided is accurate, and provided quickly, it is recommended that each area office have full time, dedicated information and referral staff. DSS staff and literature must be culturally and linguistically appropriate to families served by area offices.

   - ***Protective Response:*** The screening and safety assessment will identify circumstances where a child is at risk of experiencing or has experienced serious harm. Conditions identified during screening that indicate the need for a Protective Response are:

     - Serious physical abuse with injury or death,
     - Sexual abuse with disclosure or medical evidence, or
     - Conditions that place the child at risk of serious physical harm.

     The purposes of the Protective Response are specifically to determine: whether the serious harm has occurred or the risk of it is present, and whether further involvement with DSS is needed to maintain child safety. It is recommended that these determinations be made within 10 business days after the report is received (expanded from 10 calendar days for the existing 51B investigation). It is also recommended that the Protective Response worker partner from the outset with a worker who can continue with the family if a Family Assessment Response is required; not only will this approach provide for a seamless transition and expedite completion of the Family Assessment, but it may also promote safety for all involved. Staff conducting this response are authorized to provide services as soon as needs are identified in a brief, initial service plan.

     Protective Response outcomes include:
     1. Severe conditions (as defined above) exist. Referral of the family for a Family Assessment is required. It should be noted, as occurs now, DSS may find that a severe condition exists, but because the child has been safeguarded from the caretaker (e.g., the abuser was someone who does not reside with or have legal custody of the child), no family assessment is necessary.
     2. Severe conditions do not exist, but the child's safety is at risk. Referral of the family for a Family Assessment is required.
     3. Severe conditions do not exist, and the child's safety is not at risk. The case is closed, although the family may be informed about and request or be referred for a Family Assessment that will consider the benefit of DSS voluntary services.

     In completing Protective Responses, DSS will continue to cooperate and coordinate with District Attorneys through the establishment of multidisciplinary teams as required by MGL 119, § 51D. DSS will also continue to complete mandatory and discretionary referrals to the District Attorney when the severe condition that is found to exist meets the requirements specified by statute.

- ***Family Assessment Response:*** If the Protective Response determines that the child has experienced or is in danger of experiencing serious harm and the family may need services through DSS to maintain child safety, the family will be referred for a required Family Assessment Response. Additionally, families needing services beyond Information and Referral, who are not referred for a Protective Response, will be offered the opportunity to participate in a Family Assessment Response.

  All families are notified at the outset that **Family Assessment Response outcomes**, determined with participation of the family, include:
  1. The child's safety is at risk; the family must accept DSS services to ensure safety.
  2. The child's safety is not at risk, but the family could benefit from services. Services are offered but are not required
  3. The child's safety is not at risk, and the family does not need DSS services

  For the second and third outcomes, information, referral and follow up services will be provided at the family's request. If, during or after a Family Assessment Response, DSS learns that a child is being or has been seriously harmed, a Protective Response is initiated.

  States that have implemented a similar approach [Missouri, Minnesota, Virginia, Florida, Kentucky, Pennsylvania (counties)] found that between 70% and 75% of child abuse and neglect reports identify circumstances that do not warrant a Protective Response but are appropriate for a Family Assessment approach. Information from those that have been evaluated indicates that this approach does not result in negative outcomes for children. At DSS currently between 10% and 15% of DSS intake is voluntary, CHINS or other "non-protective" requests for service; these situations already move directly to assessment after they are identified as needing DSS services. It is estimated that additionally three-quarters of the 51A reports screened in would be appropriate for a Family Assessment Response.

  This response includes a team meeting with the family within 3 business days. With this rapid early contact, and using a team of at least two social workers, the assessment can be completed within 30 business days after the screening decision. The Family Assessment response will include identification of extended family, friends, and community supports available to the family. It will include at least one family meeting at the end of the assessment to determine Assessment outcome.

Process and Timeframes:

One: A contact is made with the Department by an individual, a family, another agency acting on behalf of the family, a court, or by report under MGL Chapter 119, § 51A. A screening and safety assessment is initiated immediately.

Two: The screening and safety assessment will determine eligibility (i.e., request involves a child or an adult formerly a child in the care and/or custody of the Department); whether an emergency response is required; whether the request reports that a child has been or is being seriously harmed. If an emergency response is required, it is initiated within 2 hours of receipt of the information. When an emergency response is not required, and If contact is made by someone other than parents, the screener will contact the parents to determine their understanding of the circumstances, unless such action would pose a risk to the child. The screening process concludes with a conference of screening staff, supervisor and manager to identify the appropriate pathway for the request/referral.

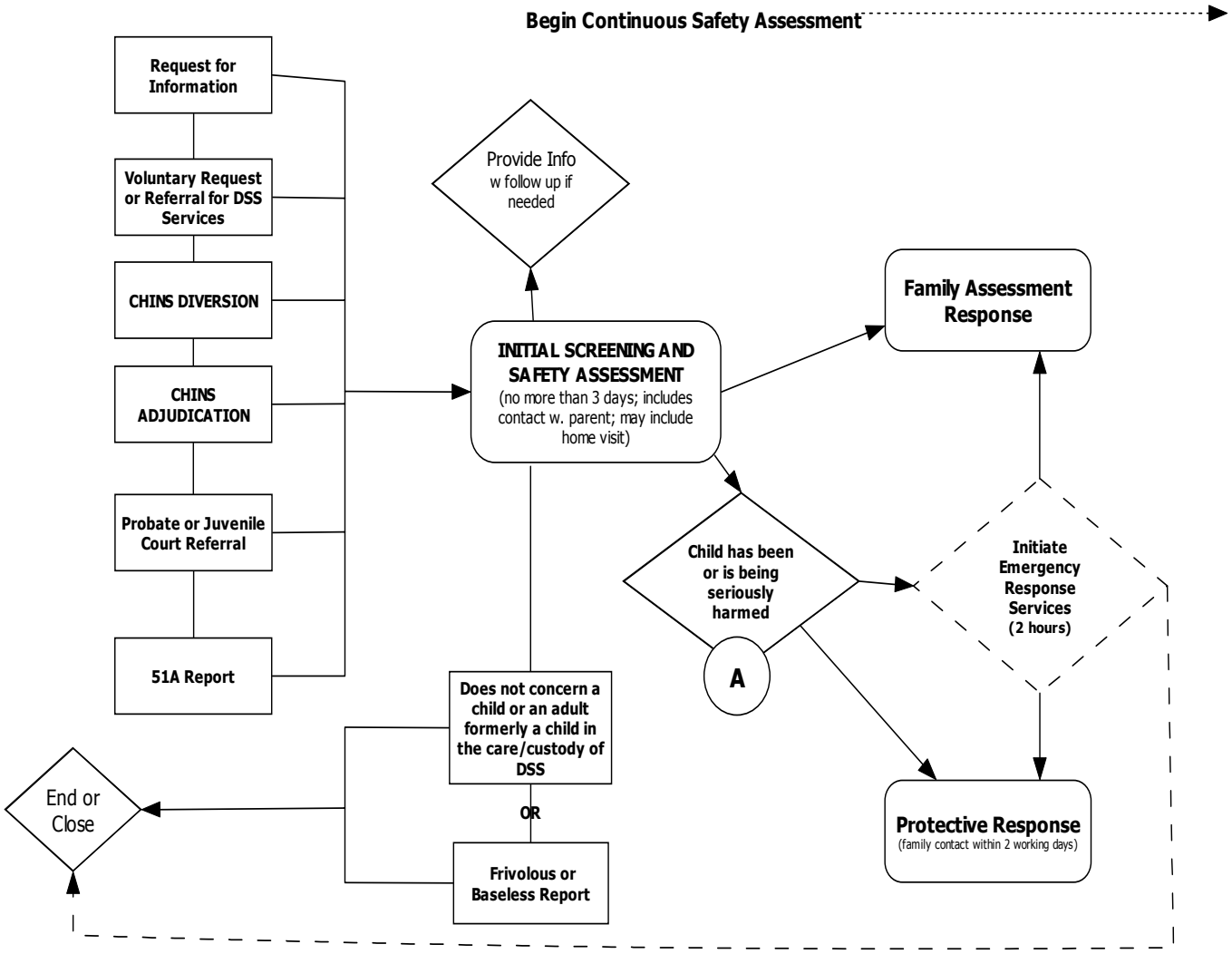
Three: When the request is for information only, information and referral services are provided. When information received does not indicate a child has been or is being seriously harmed, the family is referred for a Family Assessment. When information indicates a child has been or is being seriously harmed, the family is referred for a Protective Response.

Four: A Protective Response is initiated within 2 business days, and concluded within 10 business days, after the report is received. If the response confirms that severe conditions exist, the family is referred for a Family Assessment.

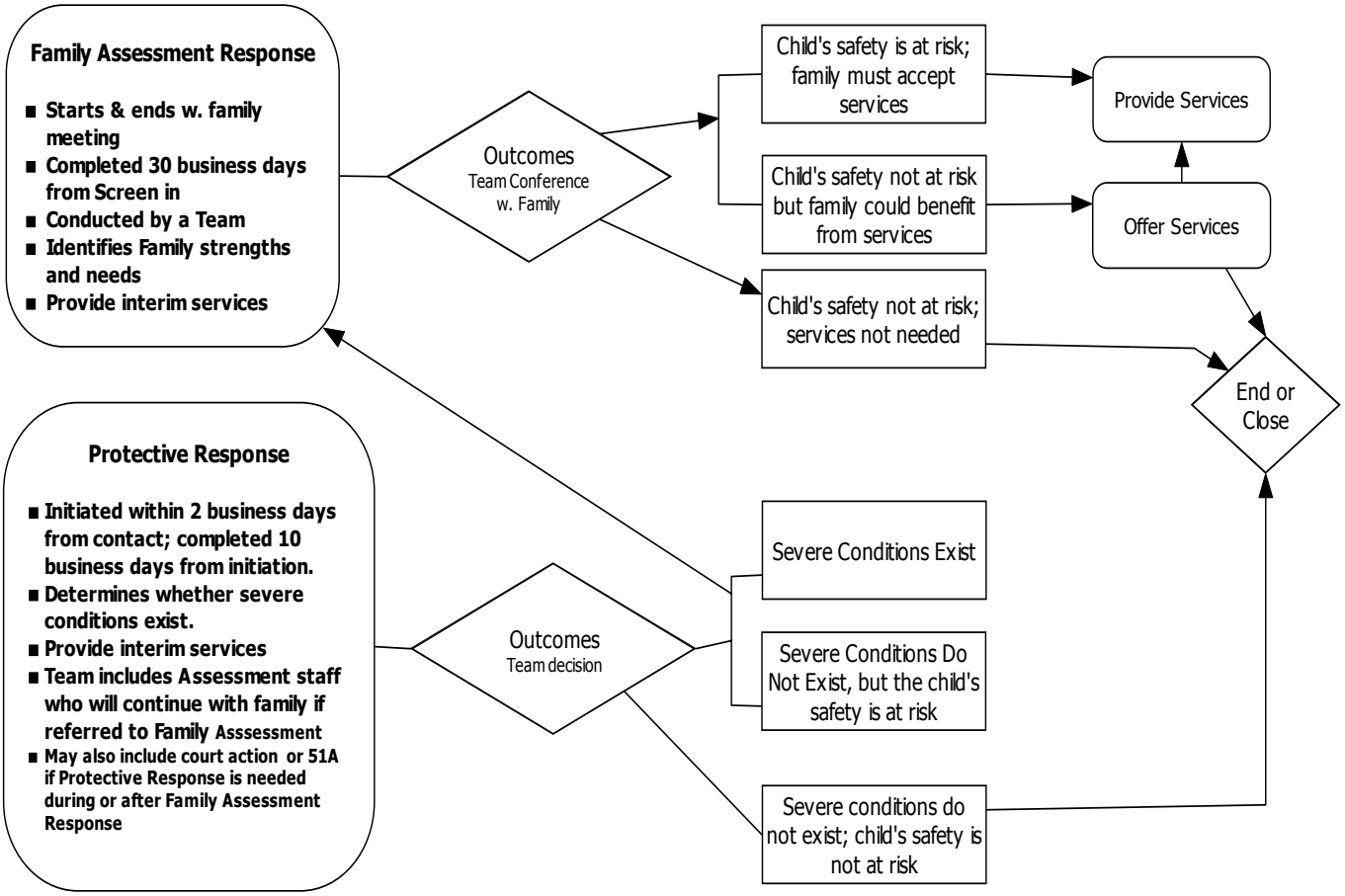
Five: When not occurring after a Protective Response, a Family Assessment Response is initiated within 3 business days of referral from Screening, and concluded within 30 business days after the screening decision.

The following flow chart presents the family engagement aspect of the model in visual form.

FAMILY ENGAGEMENT: UNIFIED ENTRY -- DIFFERENTIAL RESPONSE



Continue Safety Assessments. If risk increases Protective Response may be initiated



Questions for Reviewers to Consider about Family Engagement:

1. **In what ways do you think the family engagement component as described in the model will support working with families in a voluntary, non-coercive manner? What changes would you make, if any?**
2. **How do you think the timeliness of DSS responses will be affected by the model's unified entry component?**
3. **In what ways does the unified entry component of the model allow for greater consistency of and improved fit between families' needs and DSS responses?**
4. **In what ways does the model's screening and safety assessment component support timely DSS responses?**
5. **How does the screening and safety assessment component support DSS responses tailored to the needs and challenges of specific children and families?**
6. **How does the model's screening and assessment component provide for family involvement in decision-making?**
7. **How do you think DSS timeliness will be affected by the model's proposed differential responses?**
8. **In what ways does the differential response model allow us to appropriately match DSS responses and resources in effective ways to address children and families' needs?**
9. **How will the model's differential responses provide for family involvement in decision-making?**
10. **In what ways will the model's approach to entry result in improved engagement of families?**
11. **What changes would you make, if any, with regard to each response and how it would work?**

D. SAFETY ASSESSMENT

Philosophy/Rationale:

The model, as it emerged from the seven working groups, calls for safety to be assessed from a perspective in which concerns with danger are informed by identification of signs of safety, i.e., individual, family and community capacities for meeting a child's essential physical, developmental and emotional needs. The model places a substantially greater emphasis on the content and process of assessment than is commonly understood in current practice. The result is an approach with devotes considerable resources to developing a deep understanding families and children at the outset, then using that in-depth understanding as the basis for service planning. The model acknowledges that the scope of this assessment, and resulting service plans, is contingent upon the degree of the Department's involvement with the family.

A primary goal of the Unified Entry – Differential Response approach is to help workers, families, and community partners engage in honest, respectful and solution-focused discussions related to child well-being, permanence and safety. The project team recommends using a "signs of safety" approach for the following reasons:

- It balances the careful attention to risk factors (signs of danger) that are inherent in traditional risk and safety assessment models with a strong emphasis on identifying the caregiver, family, and community capacities (signs of safety) that can be utilized to create safe environments. In so doing, it discourages use of the terms "risk" and "safety" interchangeably and encourages more consistent practice for maintaining safety.
- It moves away from individual blame toward understanding that it is the combined individual, family and community **capacities** that contribute to increased danger or to increased safety.
- It is a balanced perspective that will help workers engage families in collaborative relationships even during times when there may be concerns for children's safety.

Definitions:

Safety: *The condition in which the combined individual, family and community capacities are sufficient to take necessary action to ensure that a child's essential physical, developmental and emotional needs are being met.*

Signs of Safety: *Observable and identifiable capacities within individuals, families and communities that increase the likelihood that a child will be physically, emotionally and developmentally protected from maltreatment and support a child's resiliency and healing in situations where maltreatment has already occurred.*

Danger: *The condition in which the combined individual, family and community capacities are insufficient to insure that a child's essential physical, developmental and emotional needs are being met.*

Signs of Danger: *Observable and identifiable lapses in individual, family and community capacities that increase the likelihood of child maltreatment and worsen its severity and impact.*

Capacities: *Individual, family, and community strengths and resources that families call upon to create safety for their children.*

How It Would Work:

The proposed **"signs of safety" approach is based upon defining and observing identified capacities** within individuals, families and communities that increase the likelihood that a child will be physically, emotionally and developmentally protected from maltreatment and support a child's resiliency and healing in situations where maltreatment has already occurred. The assessment of

"signs of safety" is a collaborative process, in which parents and community partners participate as full partners.

The project team has worked on a guide or tool that would support the signs of safety approach. Thus far, the team has considered the critical points of a child and family's involvement with DSS at which a safety assessment ought to be completed routinely. The effort has also yielded the following draft set of capacities around which the safety assessment should proceed:

Safety Model Capacities

Individual Capacities

1. The ability to demonstrate self-control to refrain from threats or acts of aggression.
2. Demonstrates the ability to modulate behaviors and emotions.
3. Demonstrates a positive perception of their child.
4. Demonstrates an understanding of and positively responds to their child's developmental needs.
5. Demonstrates the ability to protect their child or themselves from physical or emotional harm.
6. Demonstrates a willingness to engage with their child in community supports and activities.
7. Demonstrates an ability to consistently ensure adequate supervision by the parent or responsible caretaker.
8. Demonstrates an ability to utilize necessary medical treatment to ensure their own and their child's physical health.
9. Caregiver recognizes the child's perception of safety in their relationship and the child's relationships with other individuals.
10. Caregiver demonstrates the ability to maintain a home free from hazards.
11. Caregiver demonstrates the ability to provide for basic food, clothing, and shelter for their child.
12. Parent acknowledges that sexual abuse occurred and demonstrates necessary actions to insure the child's physical and emotional safety.
13. Caregiver demonstrates an understanding of the impact of substance abuse or alcohol abuse on their caretaking ability.
14. Caregiver demonstrates an understanding of how their mental or emotional health or developmental disabilities impact their caretaking ability.
15. Demonstrates an understanding of the impact of domestic violence on children and when necessary takes actions to insure both parent and child safety.
16. Demonstrates the ability to consistently regulate their child's behavior through routines and positive reinforcement.
17. Demonstrates a willingness to share their knowledge and to learn from others about the physical, emotional and developmental needs of their child.
18. Demonstrates a positive perspective of their parenting skills.
19. Ability to connect the parenting they received as a child to their approach to parenting their own child.
20. Caregiver demonstrates a positive pattern of solving problems that arise.

Family Capacities

21. Family functioning supports strong coping skills and resiliency in times of stress.
22. Family dynamics support positive and open communication between family members.
23. Family members demonstrate positive interactions and connections.
24. Family functioning demonstrates supportive and sharing adult relationships.
25. Family functioning includes extended family connections and involvement in the community.
26. Family culture encourages shared beliefs and values as the foundation for family identity.

Community Capacities

27. The community offers sufficient employment opportunities.
28. The community offers access to positive health services, educational programs, and recreational options.
29. The community has a network of boards, civic organizations, and faith groups focused on supporting families.

30. The community supports stable and connected relationships in neighborhoods over time.
31. The community has culturally competent and accessible social service support systems.

During the next phase, the team plans to consider a range of safety assessment models that have validated effectiveness for achieving family centered practice in a strength based way which might be adapted and/or customized for use in Massachusetts.

Expertise: It is important that child welfare workers are skilled in recognizing and addressing signs of danger and those skills must be supported by training, practice protocols, shared decision-making models and strong supervision. However, that must be balanced with a strong focus on recognizing and helping families develop the capacities that keep their children safe. Partnering with families to utilize and further develop those capacities – those signs of safety – is at the heart of family centered child welfare practice.

Questions for Reviewers to Consider about Safety Assessment:

1. **What reactions do you have to the model's discussion that often "safety" and "risk" are used interchangeably?**
2. **What opportunities does the use of the concept of "capacities" offer for shifting practice away from "blaming" families?**
3. **How do you think the models signs of danger and signs of safety establish clear enough markers for practice?**
4. **What are your recommendations for the routine use of safety assessment?**
5. **In what ways are the model's definitions of capacities useful in assessing safety? What is missing? What changes would you make?**

E. FAMILY ASSESSMENT

Philosophy/Rationale:

The Family Assessment Response is intended to develop a full picture of the strengths and needs of the family, and an understanding of the ability of the family and community to provide for the child's safety, well-being and permanence. This means that families will be full partners in assessing their strengths and needs. While assessment must be seen as a continuing process, when a formal assessment is completed, it should begin and end with a family meeting, whenever possible. Further, such assessments must take place promptly. This recommendation acknowledges the increased demands on staff, and includes the recommendation that responsibility for assessments should be shared among staff. A number of models to achieve this are being explored by DSS's "Teaming Project" and other efforts.

The team maintains a basic belief that a child can never have well-being without safety and permanency. However, one can easily overlook the child's well-being if families, communities or DSS focus solely on safety and/or permanency. Therefore, a fundamental question must be posed at each decision-making juncture when DSS or a community partner is involved in a child's life**: Will the action enhance or inhibit the well-being of this child**?

In studying approaches to supporting children's well-being, the team viewed the challenge to DSS as two-fold: **to assess a child's well-being on an ongoing basis, and to ensure that consideration of a child's well-being is integrated with consideration of permanence and safety as the cornerstone of DSS practice and policy**.

The team sees that the task of family assessment, as in the work about safety, requires a clear definition and renewed focus that takes DSS statutory and budgetary realities into account. The team has reviewed existing policy governing assessment and found it to be adequate, but we must enhance practice. Assessment must respond to the needs of families in the most culturally relevant manner, including attending to the growth in immigrant populations in Massachusetts. Assessment should result in information about children's countries of origin, the stories of their travel to this country, and the immigration or citizenship status of the child. Every area office should have staff with a baseline understanding of immigration status. In the education arena, DSS children should have meaningful access to educational opportunities in the same manner and to the same degree that children not involved in DSS have. DSS should have expectations that children in placement can succeed academically and that every child in placement is learning or has learned to read at grade level or is in a reading program that shows progress to that end.

Definition:

Well-being *is a measure of one's ability to function successfully in home, school and community with satisfaction/enjoyment. Assessment of well-being involves an analysis of the physical (medical and dental), mental, emotional, educational and social development of the child and an examination of a child's functioning in the home, school and community.*

How It Would Work:

1. **A Multidisciplinary Approach:** The model calls for DSS to enhance its capacity to assess and address well-being by more fundamentally integrating a multidisciplinary approach to assessment and service provision. It must be recognized that many children entering our system will have been touched by trauma, be that direct or indirect. The impact of that trauma needs to be assessed and attended to as we determine what special dimensions of assessment need to be addressed. Medication needs must be assessed with an eye toward reducing the over-medication of traumatized children. The assessment of all children must be made with an awareness of what is normal development for the child given his/her age and experiences. We do not wish to pathologize responses and reactions to life stressors. Rather we wish to

emphasize strengths as they exist and attend to needs as they arise. Individuals with competencies in the following areas should always be involved in any formal assessment of a child: child development (including normative sexual development), medical (physical and dental), mental health, and educational development and options. Family assessments should also include consultation and discussion with individuals with expertise on such issues as trauma, sexual abuse and sexual offending behaviors, disabilities (including special education), substance abuse, and domestic violence.

2. **Teaming:** Multidisciplinary work is ideal for a teaming structure within Area Offices. This may also be accomplished through other collaborations within offices which bring an array of competencies to consideration of a child's well-being. Teaming also allows families to develop relationships with more than one worker at a time, with benefits resulting to both the agency and the family. To minimize transitions and facilitate family centered practice, it is preferable to permit the assessment worker/team to remain with a family who is likely to be involved with the Department for a short time past the end of the assessment period, for example 4 to 6 weeks, before assigning the family to a worker/team who will work with them through closing. Finally, clinical staff should be identified as social workers and not case managers to emphasize their role as facilitators of continued assessment and underscore the importance of their relationship to the families with whom they work.

3. **Responsibility for Well-Being:**

   - *Families and Communities:* DSS level of responsibility for a child's well-being varies depending on the child's relationship with the agency, i.e., whether or not the child is living with his/her family or in placement. When a child is living with his/her family, the child's caregiver continues to have primary responsibility for the physical (dental, and medical), emotional and social health of the child, as well as the child's educational progress. The extent of assistance and support should correspond to the amount needed to stabilize the child within the family. Such stabilization may result in services to the family rather than to the child. In some situations, DSS may provide or arrange services to promote well-being; in others, DSS may facilitate their provision.

   - *DSS:* When a child is in placement, DSS has primary and ultimate responsibility to oversee the physical (dental and medical), mental, emotional and social development of the child, as well as the child's educational progress. Consistent with family centered practice, the Department should implement its responsibility in collaboration with the child's parent whenever possible. However, a parent's unavailability, unwillingness or inability to address his/her child's well-being, does not excuse inattention to the well-being of a child in placement. When exercising responsibility as the child's primary caretaker, DSS practice remains consistent with its Core Values, involving the parent in all aspects of the child's well-being whenever possible,

   - *Children Placed in Residential Settings* need to have their social and relational needs and skills attended to on an ongoing basis, informed by knowledge of normal child development. Relationships and access to them should not be used as discipline or "consequences." It is precisely these relationships that are essential to positive outcomes for children and youth in care. Research has demonstrated that youth transitioning back into the community have a more difficult time making positive adjustments in direct relationship to the degree they are isolated from the outside community. Family Assessment should continue even when a child moves to or resides in a residential setting.

   - *DSS and Community:* A child's well-being is directly related to, and a function of, the health and well-being of the family and community in which the child lives. Research shows that family difficulties, such as family violence, substance abuse, compromised mental, emotional and/or physical health, and economic insecurity, may impact a child's physical, mental and emotional health and development, and educational progress. By focusing on the full range of

family stressors which undermine child well-being, outcomes will improve and successes will endure. Family assessments must continue to focus on mental health, domestic violence and substance abuse. DSS must build and support structured and consistent partnerships with state agencies and community agencies around addressing issues such as poverty, housing, and employment. DSS must also build competencies within its staff around these larger social and community issues. These steps are essential if our work is to have a chance of success and to be responsive to a family's stated needs.

4. **Assessment Triggered by Key Events in the Work with the Family**. Following the initial assessment, the following events will result in a limited reassessment which may include a safety assessment:
   - service planning
   - permanency planning
   - transitional placement
   - major life/family changes
   - service plan updates
   - foster care reviews
   - group care reviews
   - clinical reviews

5. **Assessment Supports:** The team reviewed many guides and processes to aid in the focus on well-being in the process of assessment. The team has drafted a *Developmental Matrix* intended to assist social workers in assessing a child's status, and in providing appropriate referrals when needed. The team has also identified a number of supplementary tools which DSS could make available to assist parents and social workers in understanding children's developmental needs and challenges. *Family Circle of Support* refers to a specific method used in the Connecting Families model (described briefly in "Community Partnership" above) which aids in the identification of a family's formal and informal community connections. This is critical in drawing in existing and potential supports, and in identifying kin who might be able to provide care for children. This approach requires that DSS have access to information and guidance to help families make meaningful connections to a community's formal and informal resources and support networks. Additionally, the Family Networks initiative is examining the viability of adopting the Child and Adolescent Needs and Strengths (CANS) guide to support levels of service decision-making.

Questions for Reviewers to Consider about Family Assessment:

1. **In what ways does the model's Family Assessment Response shift practice to a better focus on well-being?**
2. **In what ways do the model's multidisciplinary approach, teaming structure and family involvement provide for comprehensive input into decisions?**
3. **In what ways do you think features of Family Assessment identified by the project (see 1 through5 above) will achieve sound results? In what ways would you change or expand upon the project's recommendations?**
4. **In your opinion, what guides or tools hold the greatest potential for family engagement, accurate assessments and right-fitting service planning?**

F. DEVELOPING AND SUPPORTING LIFE LONG PERMANENT RELATIONSHIPS

Philosophy/Rationale:

Every action, from screening through initial assessments and service plans, must include identification of relationships in the child's life that are secure, safe, stable and committed to lifelong support. In particular, service plan goals should specify actions to be taken to support those relationships.

Permanence is locating, supporting and keeping a lifelong family. It is achieved through:

- Relationships that offer safe, stable, and committed parenting, lifelong emotional support, and family membership status;
- *Familial connection and relationship that lasts beyond the youth turning 18 years of age.*
- Ensuring that no child/youth moves into adulthood without a meaningful permanent familial connection.

The concept of permanence is weaved throughout DSS's involvement with a family, bringing physical, legal, emotional safety and security within the context of a family relationship and multiple relationships with a variety of caring adults.

The practice of Permanency recognizes that:

- Every child/youth is entitled to a **permanent family relationship**. DSS' commitment to achieving this goal is demonstrated by engaging families, multiple systems and the community at large in the effort to identify and support familial life long connections and relationships.
- Each **child/youth drives the process** themselves in full partnership with their families and the agency. Through the child/youth's participation, their input in all decision-making and planning for their futures, the agency recognizes that they are the best source of information about their own strengths and needs.
- A stable, healthy and lasting living situation takes place within the context of a **family relationship with at least one committed adult**; reliable, continuous and healthy connections with siblings, birth parents, extended family and a network of other significant adults; and education and/or employment, life skills, supports and services.
- **Concurrent planning** occurs when working simultaneously towards both placement prevention and possible placement resources. The social worker, in partnership with the parents and kin, will identify families and individuals known to the child who might be able to care for the child if the need arises. Plans may involve placement with kin. If the prognosis for reunification is poor, the plan may provide for identification of the child's current foster care provider as a potential permanent family or placement with another approved provider who is able to make a permanent commitment to the child should reunification not be accomplished.
- It's **built upon the strengths and resilience** of the child/youth, their parents, families, and other significant adults.
- Assures that the provision of services and supports is **fair, responsive, and accountable** to child/youth and their families, and therefore, does not stigmatize them, their families or their caregivers.

When placement is necessary, the placement plan must include provision for supporting existing attachments and must specify the plan for locating alternatives. Such planning must be included at the outset of any placement. In addition, the service plan goals should address the ways in which family relations will be preserved or secured.

Definition:

Permanence *occurs when children have relationships that offer safe, stable and committed parenting, lifelong emotional support and family membership status that lasts beyond age 18. It is achieved through the preservation of an intact family or securing of a family through reunification with birth family, legal guardianship or adoption; placement with kin; or the forming of connections with other caring and committed adults.*

How It Would Work:

1. At first contact with DSS, the family should be asked to **name relatives (including birth fathers and mothers who may not be evident), extended maternal and paternal family, friends** who are supports to the family as part of the normal course of engagement. If placement becomes necessary, this resource list is available. Before resorting to a "non-kin, a "kin" must be considered first. "Kin" is defined as those persons related either by blood, marriage or adoption (i.e., adult sibling, grandparent, aunt, uncle, first cousin) or a significant other adult to whom the child and parent(s) ascribe the role of family based on cultural and affectional ties or individual family values.

2. For youth age 17 and older, together with their social worker, lead agency provider or resource parent and biological parents, should complete an **Adolescent Permanency Transitional Planning** Meeting Form and Checklist to ensure the youth will have what they need to live successfully as adults.

3. DSS should continue to **allow youth** who left DSS care at or after age 18 **to return** to the agency upon need of assistance and request supportive services. This practice provides the Department and youth additional time to plan and achieve discharge permanency goals.

4. **Identify the child's permanency goal as such in each service plan**, thus making it clearer to families, social workers and all providers.

5. Involve older youth in **Foster Care Reviews & Permanency Planning Hearings:**
   - Youth age 16 and older must be present at Foster Care Reviews and Permanency Hearings and consulted regarding goal and services or, at very least, youth's written input is required.
   - Prior to the establishment of the anticipated new permanency goal "Alternative Planned Permanent Living Arrangement" (APPLA) for a youth, she/he must meet with the area director or clinical team to assess the appropriateness and to re-assess the possibility of family reunification.
   - The area director or clinical team should meet with youth with a goal of APPLA before case closing to ensure life long connection is established and the youth has the capacity to live successfully as an adult.

Questions for Reviewers to Consider about Developing and Supporting Life Long Permanent Relationships:

1. **How does the model's definition of permanency support working with families right from the start?**
2. **How does discussing permanent plans at the initial involvement impact family engagement?**
3. **How does the involvement of kin, as described in the model, support positive outcomes for children?**

G. SERVICE PLANNING AND PROVISION

Philosophy/Rationale:

The assessment provides the foundation for the service plan, with primary goals related to safety, well-being and permanency. The scope of the service plan should reflect the degree of the Department's involvement with the family.

The results of the developmentally informed child well-being assessment should be reflected in the service plan in terms of supports the child might need, regardless of whether providing the support directly falls within the Department's mandate. In addition, when placement is necessary, service plans must include a **Child Profile**, which consists of:

- The names and addresses of the child's health and educational providers
- The child's school record
- A record of the child's immunizations
- The child's known medical problems
- The child's medications
- Any other health and education information about the child DSS determines appropriate
- Assurance that the child's placement in foster care takes into account the proximity of the school in which the child is enrolled at the time of placement.

Throughout, services plans, the planning process, and service provision should be characterized by the following:

- **Strength-Based:** Service plans must be built on recognition of the families' strengths and needs. The Department has substantial expertise in this area, and is capable of further building and supporting this practice. For example, in the recommended strength-based model The "Problem Statement" and the "Indicators" were eliminated and the Strengths/Needs statements and goals were added for both for the family and the Department. Close attention is paid to written and verbal language to reflect strength based approach. To ensure that family's voice was heard and that their input was built into the model up front, the strength based service plan draft document was simplified by the project team to make it more relevant, in the family's own language and "user friendly".

- **Service Planning is a Process, Not an Event:** Service planning is an ongoing process during the Department's involvement with a family. Service plans may change as family circumstances change, and updates should reflect successes achieved throughout DSS involvement with the child and family, by including reference to achievement, continuing success, ongoing competency.

- **Safety, Well-Being and Permanence – Beginning to End:** All family members must be given opportunities to acquire and develop the array of life skills necessary to create safety and well-being within their family and community environment. Similarly, children and youth who are in placement must be given opportunities to acquire and develop the array of life skills needed to become an independent and interdependent adult. Therefore, service plans must address each of these areas from the start.

How It Would Work:

- Service planning will occur within 10 working days after a family enters the Family Assessment Response pathway. The subsequent plan will be developed 55 working days after the case has gone beyond the Family Assessment Response.

- Service plan updates will reflect successes achieved throughout the life of the case. Reference made to – "achievement – continuing success – ongoing competency" – is added to the Strengths

narrative. This shows progress toward permanency and case closing and more content in the Strengths rather than in the Needs sections.

- Development of service plans will involve use of the "signs of safety approach"-capacity assessment and well-being assessment by the social worker and family.

- Concurrent or contingent planning will be part of the service planning process from the beginning and will be reflected in the service plan document as a mechanism to attend to permanency.

- Use of the Child Profile included in the Strength Based Service Plan.

Questions for Reviewers to Consider about Service Planning and Provision:

1. **What are the benefits and challenges of using a Child Profile in the service plan?**
2. **What steps should be taken to achieve the model's recommendations regarding those qualities that should characterize service plans, service planning and service provision, i.e., that they are strength based; that service planning is a process and not an event; and that they need to address safety, well-being and permanency from beginning to end?**
3. **What additional resources do you feel will be necessary to achieve service planning as described in the model?**

H. CASE CLOSING: PLANNING FROM THE BEGINNING

Planning for the end of DSS involvement with a family begins at entry. The outcomes needed for case closing should be fully explored with the family during initial and subsequent assessments and service planning, and clearly specified as such in any service plans that are developed with the family. In this way, all participants are fully informed of possible effects and consequences of actions.

For older youth, the service plan and case closing is about monitoring their progress toward permanency and life skills development. The team recommends use of an Adolescent Permanency Transitional Planning Meeting to identify and to document the youth's needs and to address the progress made toward achieving their permanency goal, education, employment, and life skills development.

For all families, the team recommends a case closing conference, which whenever possible includes the parent(s) and child(ren). This conference should develop, and commit to writing, the plan for closing the case. It is recommended that when DSS involvement with the family has been longer term, the plan be in place at least 90 days before the case is closed. Again, the discussion and plan should be the result of joint action and decision, not the responsibility of one person alone.

Questions for Reviewers to Consider about Case Closing:

1. **How would change or expand upon the project's recommendations for closing cases in ways that support or improve working with families right from the start?**
2. **What additional steps might be included in this component?**

II. MEASURING SUCCESS

From the beginning, the team has been committed to evaluating whether the project will result in positive outcomes for families. The following summarizes approaches the team recommends for this purpose.

Measuring Improved Perceptions of Practice:

The team studied ways of obtaining input from consumers, staff and the community, including instruments and scales developed and in use in other states. The result is a recommendation that study of WWFRFS implementation should focus on the specific perceptions of DSS within certain defined groups from the broad array of those who will be affected. The survey should evaluate both the impact on the Department's work with children and families and the fidelity of that work with the Department's core practice values.

The ***what*** we propose to measure will center on feelings and thoughts that these groups experience when interacting with DSS. Examples include the subjective experience of consumers in areas such as feeling heard, accepted, blamed, respected, safe, understood, supported, helped, and encouraged. From the community, information about their experience of feeling heard, informed and having an appropriate response to their concerns will be sought. As always, staff perceptions of change in their practice will be a crucial inquiry: whether staff perceives WWFRFS to be effective, and their thoughts and feelings about the change.

The ***who*** that we have identified fall into five categories:

- Children
- Families
- Community Partners, including but not limited to: DSS service providers, law enforcement, school personnel, medical providers, the legal community, faith-based organizations, community service organizations, child care providers
- DSS Staff
- Foster Families

Measuring Practice Change:

The team has begun to identify already available information that might be used to measure WWFRFS impact on desired practice outcomes. Examples of measurable data the DSS information system currently captures include (but are not limited to):

- timeliness of investigations, assessments, service plans and medical/dental appointments
- number of protective intakes screened in, investigated & supported, together with the types of allegations
- status of cases open and closed in a given month categorized by type of intake (e.g., protective, voluntary, CHINS, court referred, etc.)
- home visit timeliness and consistency
- social worker workload
- staff training
- Department of Education information, including MCAS scores, IEP and attendance information
- costs by service referral made for foster care, family based services and contracted placement services
- community connections outcomes measures

The team has also reviewed statistics gathering programs now using FamilyNet and other DSS-related databases to produce output reports, such as DataMart, Batch Reports, CQI Reviews. The reports on the data topics listed above and more are currently available for workers, supervisors, and management in various formats on both periodic (e.g., monthly and annual) and ad hoc bases.

The team recommends identifying, prior to implementation, outputs that will provide statistically measurable indications of the project's impact on crucial practice outcomes over time. Pictorial comparisons (charts, graphs, reports) should be presented for the agency and the public to review after a meaningful implementation period has elapsed.

Putting It Together – Surveys and Statistical Changes Analyzed:

The ultimate goal of this effort will be a concrete analysis of the changes that flow from the WWFRFS project. The data from surveying perceptions and statistically analyzing changes outcomes will allow DSS to frame and answer questions about the project's impact on a deeper level. We fully expect that the results will verify an agency on the upswing that works with families in a collaborative, strength-based way in meeting children's needs for safety, well-being and permanence.

Questions for Reviewers to Consider about Measuring Success:

1. **How would you change or expand upon the model's recommendations about measuring perceptions about the ways in which implementation of WWFRFS affects practice?**
2. **How would you change or expand upon the model's recommendations for measuring practice outcomes following implementation of WWFRFS?**
3. **What additional measures of practice change do you recommend?**

III. SUPPORTING ORGANIZATIONAL AND PRACTICE CHANGE

From reviewing the experiences of other states, we learned that states best managed major organizational change because of:

- Statewide acknowledgement that the child welfare reform is needed
- High level commitment to building a strength based child welfare system
- Active involvement of all stakeholders, parents and consumers, and community
- A dynamic "action agenda" for planning and implementation
- A realistic timeframe from development to full implementation (5 to 10 year plans)
- Communication/marketing to public and staff of progress throughout the process.
- Recognition of the need to support staff with training and other supports and by establishing workloads and caseloads that allow social workers time to adequately and professionally perform their duties.

Inspired by this information and WWFRFS's shared vision and guiding principles, the team went beyond conceptualizing a model for how to work with families right from the start to begin to develop recommendations for making it happen in reality. The first set includes ideas for communicating with staff, community and parent partners about the project, its goals and what is needed to build it. These recommendations reflect the team's view these kinds of changes require broad-based understanding, support and participation. The second set includes ideas for sustaining the changes.

Before implementation can be completed, the project team intends to identify the "core competencies" that will support the development of staff who are fully trained and prepared for working with families right from the start.

Communicating and Implementing WWFRFS:

It was determined that achieving the best outcomes for the project would require that strong communication be maintained among the project's Steering Committee, team leaders and work group members as the process of communicating about the project moves forward. Ongoing communication through a variety of approaches will create a learning environment, in which implementation progress can be measured and a culture of constant reflection in which practice is continually assessed and avenues for improved quality are continually sought. The following summarizes the recommended approaches for communicating about the project and creating the internal and external "culture change" necessary to support its implementation.

<u>Use Existing Forums</u>

- Work with each regional and area director with to create a communication, implementation, and feedback plan.

- Integrate training into DSS Statewide Manager Meetings to support regional and area directors in developing the plan.

- Include WWFRFS on the agendas of the following regular meetings:
    - Management meetings at all levels:
        - central
        - regional
        - area
    - Regional director meetings
    - Regional counsel meetings
    - Regional Hotline meetings
    - Staff meetings
    - Supervisors meetings
    - Specialty Staff meetings

Establish Area Office Development Teams

- Based on an "Equipping the Leaders" model, identify area office staff to be trained in and help to distribute the WWFRFS message and/or piggy back this effort on to the Family-Centered Practice training.

- Understanding that all staff will eventually be trained on WWFRFS, give area offices ownership of how they want to learn about this project. Workers are the experts about how they can best learn these concepts.

Work with Partners

- Identify a staff person in each region or area office to "bridge" with community partners.
- Use the many existing forums; modify the presentation to be relevant to each audience.
- Manage the media; this cannot be overemphasized.
- Use existing professional marketing resources (Barry and Eliot, Jack Williams); seek funding to hire a marketing consultant to support this effort.
- Involve Area Boards.
- Continue to lobby the legislature; additional one-time and ongoing funding is likely to be needed and statutory changes may also be needed.

Plan Ongoing Forums to bring people together around Family-Centered Practice and WWFRFS such as:

- Area office case discussion groups.
- "Learning circle" meetings, in which people of same role (e.g., supervisors) from different offices meet to discuss what is and is not working in their offices (recommend that these be regional for accessibility).
- Area office book clubs which focus on strength based, solution focused literature.
- WWFRFS group members joining the current Mentoring Program.

Use Information and Technology

- Continue to post information regarding WWFRFS on the DSS internet site; announce new developments using statewide e-mail and link to the internet site via "What's New" on the DSS intranet site.
- Create and distribute a videotape ("infomercial").
- Develop interactive computer based training and incorporate tracking to ensure that each employee has completed the module.

Sustaining Practice Change:

After the project's practice objectives have been introduced, the task becomes one of sustaining the effort. The following steps are recommended for this purpose.

Use the Child Welfare Institute (CWI)

- Develop a training plan for all audiences to be conducted via area and regional based training tied into curriculum currently being developed for Family-Centered practice.
- Direct central office management team to support integration of WWFRFS through established means such as Foster Care Review and with other project initiatives such as Family Networks and "teaming."
- Expand leadership development to include understanding of parallel process, i.e., that the manner in which staff are treated by leadership will be reflected in the way that staff treat families.

Pursue Accreditation by the Council on Accreditation (COA) "The COA partners with human services organizations worldwide to improve service delivery outcomes by developing, applying and promoting accreditation standards." (Mission Statement from COA). The project team recommends DSS become accredited by COA, because the process will support the WWFRFS message, support family centered practice training, support and help sustain practice, validate the culture change process, professionalize the work we do, help set standards and evaluate practice. *[See www.coanet.org for more information.]*

Involve CQI

- Expand CQI teams to include providers, schools, courts, FamilyNetworks Coordinator/FBS Coordinator, Resource Coordinators, and Family Group Conference Coordinator; this will promote review data/trends issues from a strength based perspective.

Commit to Continuous Learning; When managers and supervisors encourage and support continuous learning for all staff, WWFRFS concepts will flourish in practice.

Use Technology

- Provide field staff with appropriate hardware & software that supports their ability to work in family centered ways, e.g., the capacity to develop a strength-based service plan with a family during a home visit.

Questions for Reviewers to Consider about Supporting Organizational and Practice Change:

1. **How would you change or expand upon the model's recommendations about communicating and implementing WWFRFS?**
2. **How would you change or expand upon the model's recommendations for sustaining practice changes brought about by WWFRFS?**
3. **If the model were to be implemented, what should be added to the core competencies?**
4. **What resources do you think are needed to sustain organizational and practice changes as recommended in the model?**
5. **How can families and communities contribute to sustaining this change?**

IV. CONSIDERATIONS

The team was encouraged to work creatively, unrestrained by budgetary, statutory or other such practical concerns. The following are some of the areas where the team acknowledges re-design or creation of DSS systems, organizational capacities or other changes will need to occur:

Staffing and Staff Development:

- A major theme of the model is reduction of the "one worker per family" model in favor of increased use of multi-staff approaches. Examples are the pairing of a Protective Response worker with a Family Assessment worker and of two workers during the Family Assessment Response. DSS is currently studying various approaches to what is referred to as "Teaming," including the teaming of parent partners with DSS workers. The team recommends that WWFRFS be kept in mind in during the evaluations of these projects.
- Increased staffing will be needed to provide for "teaming" processes, to expedite Protective and Family Assessment Responses and to address an anticipated increase in referrals.
- Caseloads and workloads need to be realistic and based on the time available to complete the assigned work.
- Caseloads should reflect the professional standards for the job function and not exceed realistic expectations.
- Redesign of job titles and functions will be necessary.
- Community partnering will be necessary to support provision of information and referral staff at the front door.
- Staff able to speak the languages spoken in the community served by each area office must be available.
- Clinical staff should be identified as social workers and not case managers to emphasize their role as facilitators of continued assessment and underscore the importance of their relationship to the families with whom they work.
- While the model will require an array of training efforts, some specific areas are identified:
    1. Additional skill training is needed for workers to address permanency with children and youth. For example, working with a youth age 13 or older who wishes not to be adopted requires a SW who not only values permanency but is also able to address it clinically with the youth.
    2. Child development training is essential for staff implementing recommendations concerning the assessment of child well-being.
    3. All social workers (protective, assessment, ongoing, adolescent/CHINS—not just adoption workers), resource parents and lead agencies should be trained to address the issue of permanency with children and youth regardless of the service plan goal.
    4. Social workers should have initial and ongoing training in the skills of understanding and building relationships.
    5. Social workers should have initial and ongoing training which will enable them to recognize, respect and value the unique culture of each family.
    6. Social workers will need to have time available to attend training without a negative impact on their workload.

FamilyNet:

- The front end of FamilyNet will need a comprehensive redesign to alter formats, language and timing of information entry, in order to capture changes resulting from the Unified Entry – Differential Response system.
- Guides such as are under consideration by the team for safety assessment and the assessing child well-being will require new FamilyNet components.
- It is recommended that FamilyNet be thoroughly reviewed to ensure that its design, layout and language reflects a strength based, family centered approach to services.
- Elements of the Child Profile will need to be included FamilyNet.

- Permanency outcomes for youth age 17 and older as well as education and employment status also need to be measured.

Department Literature:

- Case closing meeting and letter should address the rights of youth and families to request services after case closing and the right to appeal the case closing, including the fact that all services remain intact until the decision on any appeal is made.
- Rather than tinkering with existing intake literature, a new body of literature should be designed. This literature must avoid jargon, offensive and hyper-legal phrases such as "alleged perpetrator", and fill-in-the-blanks formats. It must include clear, comprehensive, and engaging descriptions of what a family can expect in working with the Department. Literature must be translated into languages other than English, specifically the dominant languages spoken in the communities served by each area office.

Information & Referral Functions:

- Resources and planning will need to be devoted to development of and maintaining information about resources for the area offices, including statewide programs such as MassHealth or WIC.

Other:

- Service Provision: Staff and families will need speedy access to services, whether provided by Department staff or by providers under contract to the Department. In addition, the Department may need to develop agreements and/or systems to ensure ready access to services not provided directly or by purchase.
- Transportation: Creative efforts are needed to address the fact that frequently families lack transportation which affects their abilities to connect with community-based programs and services.
- Central Registry: The requirements, process and use of the Central Registry will need to be re-examined.
- Court Cases: Current models for preparation and presentation of court cases will need to be re-examined.
- Reports of Abuse and Neglect in Institutional Settings: The current system for responding to reports of abuse and neglect in DSS foster homes, community residential care and other institutional settings will need to be examined to determine whether a distinct pathway is required for these circumstances.
- Testing and Validating Proposed Tools: Proposed guides and tools will require testing regarding the validity of their concepts and reliability of their measurement.
- Privacy: Legal requirements governing preservation of confidentiality and the circumstances under which information can or must not be shared will be need to be reviewed as the model is further developed.
- Incorporation of Specialized DSS Resources: Further designing will need to plan for facilitating access to specialized DSS resources such as the Collaborative Assessment Program and the substance abuse, domestic violence, mental health and education specialists.
- Hotline: Integrating the Hotline into the model is a task for future designing and planning.

Questions for Reviewers to Consider about Related Systems, Organizational Capacities and Other Changes:

1. **What additional considerations must be taken up to support improved work with families right from the start?**
2. **What impact do you believe the model will have on practice, related systems and organizational capacities?**
3. **How would you recommend that DSS, families and communities dialogue, prepare and respond to the impact you anticipate?**

V. SUMMARY

As stated in the Introduction, the concept model is being presented to foster dialogue and problem-solving in the broad community of people affected by DSS practice. Since September 2004, the team of over 90 staff and family and community leaders has endeavored to define what it means for DSS to work with families right from the start. The effort has built on DSS's core values, that practice be child-driven, family centered, community focused, strength based, committed to cultural diversity/cultural competency and committed to continuous learning. The team has created a shared vision and specified guiding principles for family centered practice. Now, reviewers are being encouraged to evaluate the team's model from the perspective of their own experience, to ask questions of team members and to provide feedback, in the belief that through broad-based participation a new, improved way of working with families right from the start can be built.

VI. WORKING WITH FAMILIES RIGHT FROM THE START TEAM MEMBERS

Engagement & Responsiveness with Families	Well-Being
Ken Pontes, DSS Northeast Regional Director, Team Liaison ***Leslie Akula, DSS Director of Policy Support, Steering Committee*** 1. Maud Aldrich, Community Health Link, Community Partner 2. Barney Keezell, DSS, Director of Fair Hearings 3. Bob Kelley, Community Partner 4. Lisa Lambert, Assistant Director of PAL, Community & Parent Partner 5. Sheila McMahon, Community Connections, Community Partner 6. Luz Mendez, DSS Cambridge Intake Supervisor 7. Joyce Nardine, DSS Framingham Area Director 8. Clare O'Donoghue, Parent Partner 9. Kate Potter, DSS Metro Regional Office, Attorney 10. Mark Sawula, DSS Springfield Area Program Manager 11. Kevin Terrill, DSS Cape Cod Area Office Supervisor 12. Irene Woods, DSS Greenfield Area Office Supervisor	***Kathleen Donovan, DSS Mental Health Specialist, Team Liaison*** ***Dianne Curran, DSS Deputy General Counsel, Steering Committee*** 1. Marcine Fernandez, Wareham School District, Community Partner 2. Sue Hannigan, Community of Care, Community Partner 3. Noemi Mendez, DSS Worcester Area Office Supervisor 4. Courtney Pace, DSS Fall River Area Office Assessment Worker 5. Barbara Pierce, DSS Brockton Area Office Supervisor 6. Gus Rego, DSS Malden Area Program Manager 7. Kim Ross, DSS Northeast Region Resource Coordinator 8. Kim Stevens, Parent Partner 9. Margaret Winchester, CPCS/CAFL, Community Partner 10. Andrea Vandeven, Children's & Mass. General Hospitals, Community Partner
Safety	**Planning Services for Achieving Permanency**
John Vogel, DSS Director of Training, Team Liaison ***Brett Antul-Cabral, DSS Cambridge Area Office Investigator & Local 509, Steering Comm.*** 1. Mia Alves, DSS Springfield Area Office Investigator 2. Mary Calo, DSS North Central Intake Worker 3. Ann Furlong, DSS Coastal Assessment Worker 4. Susan Goldfarb, Suffolk County Children's Advisory Center, Community Partner 5. Bob Maker, DSS Haverhill Area Program Manager 6. Bernie McCrevan, Boston Police Department, Community Partner 7. Andrew Rome, DSS Western Regional Office, Attorney 8. Raquel Serrano, DSS Holyoke Supervisor 9. Cindy Stovall, Parent Partner 10. Scott Scholefield, DSS Director of Special Investigations & Case Investigations 11. Dan Wallach, Parent Partner 12. Rich Young, Judge Baker, Community Partner	***Monica Murphy, DSS Attorney, Team Liaison*** ***Gail Parker, DSS Worcester Area Program Manager, Steering Committee*** 1. Mia Alvarado, DSS Chief of Staff 2. Maureen Fallon Messeder, DSS Director of Adolescent Services 3. Jamie Ledoux, DSS Haverhill CHINS Worker 4. Lucy Marshall, DOC Clergy, Community Partner 5. Irene Michaud, DSS Planning & Program Development 6. Ilene Mitchell, Probate Court Liaison for Child Welfare Cases, Community Partner 7. Mike Pacheco, Parent Partner 8. Sally Rando, DSS Framingham Area Program Manager 9. Diane Robertson, Kid's Net, Community Partner 10. Pat Walsh, Deputy Commissioner for Probation

Community Partnerships	Measuring Our Success
Daniel Lewis, DSS Family Support Manager, Team Liaison ***Gwen Healey, Parent Partner, Steering Committee*** 1. Kristin Alexander, DSS Mental Health Specialist 2. Zevorah Bagni, DSS Lowell Area Office Supervisor & Local 509 3. Bill Brown, DSS Park Street Area Director 4. Bonnie Chalifoux, Community Partner 5. Susan Connelly, DSS Hyde Park Area Program Manager 6. Monica Fernandez-Castro, MSPCC, Community Partner 7. Dianne Holcomb, Community Partner 8. Jaye Susan Richards, DSS Cape Ann Area Office Screener 9. Pat Scibak, DSS Central Regional Office, Regional Counsel 10. Joan Shahdan, DSS Brockton Area Office Social Worker	***Michael MacCormack, DSS Manager of Continuous Quality Improvement, Team Liaison*** ***Ros Walter, DSS Information Technology, Steering Committee*** 1. Bob Baptista, DSS Director Foster Care Review 2. Maureen Clayton, DSS Lowell Area Office Supervisor 3. Mary Connors, Haverhill Protective Services, Community Partner 4. Pam Cruz, Community Connections, Community Partner 5. Lois Eaton, Hampden County Juvenile Court, Community Partner 6. Susan Ivey, Parent Partner 7. Tom Malone, DSS Metro Regional Office, Regional Counsel 8. Roxann Mascoll, DSS Domestic Violence & Family Support 9. Debbie Sicilia, DSS Western Regional Office Resource Coordinator 10. Harry Sloate, DSS South Central Area Office Investigator 11. Judy Vander May, DSS Cape Cod Area Program Manager
Building a System to Support Practice Change	
Marcia Graves Roddy, DSS North Central Area Program Manager, Team Liaison ***Beryl Domingo, DSS Office of Field Operations & Support, Steering Committee*** 1. Joe Castro, DSS Information Technology 2. Amanda Flood, DSS Cape Ann Area Office Social Worker 3. Jackie Harris, Parent Partner 4. Peter MacKinnon, DSS Lowell Area Office Supervisor 5. Heather Meitner, Children's Trust Fund, Community Partner 6. Judy Morrison, DSS Boston Regional Office, Attorney 7. Michael Pay, DSS Southeast Regional Office Quality Assurance Specialist 8. Lisa Peterson, DSS Hyde Park Area Office Investigator 9. Pamela Rheaume, DSS Training Unit 10. Carlton Watson, Community Partner 11. Karen Wilson, DSS Harbor Area Office Supervisor	

Also participating as Steering Committee members are: Liz Skinner-Reilly, Virginia Peel and John Zalenski.